breaking U.S. law to subsidize the Palestinian Authority's support for terrorism.

A few years back, Congress passed the Taylor Force Act, which prohibits nonhumanitarian aid to the Palestinian Authority until it ends its so-called martyr payments—a euphemism for bounties given to Palestinian terrorists or their families for maiming and killing Jews. So the administration has, instead, funneled tens of millions of your tax dollars to nongovernmental organizations to build roads, sidewalks, parking lots, and other infrastructure projects on behalf of the Palestinian Authority. As a result, since money is fungible, the Palestinian Authority can ignore these basic responsibilities of government and, instead, keep pouring more money into its pay-for-slay program.

The contrast couldn't be starker. If the Palestinian Authority wants to bankroll terrorists and their families, the Biden administration will contort the law beyond recognition to fund the Palestinians; but if a center-right government gets elected once again in Israel, the Biden administration will work overtime to undermine it. This is exactly backward. We should demand the Palestinian Authority stop subsidizing terrorism before it gets another penny of your tax dollars.

While we are at it, we should pass the Taylor Force Martyr Payment Prevention Act, which I am reintroducing this week, to sanction foreign banks that process these so-called martyr payments for the Palestinian Authority.

Meanwhile, President Biden and his administration should quit treating Prime Minister Netanyahu like he is a rival or even an adversary and start treating him as he is—a war hero, a courageous patriot, a towering figure of modern Israel, and most importantly for us, a great friend of America.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 95—HONORING THE LIFE OF DR. PAUL FARMER BY RECOGNIZING THE DUTY OF THE FEDERAL GOVERNMENT TO ADOPT A 21ST CENTURY GLOBAL HEALTH SOLIDARITY STRATEGY AND TAKE ACTIONS TO ADDRESS PAST AND ONGOING HARMS THAT UNDERMINE THE HEALTH AND WELL-BEING OF PEOPLE AROUND THE WORLD

Mr. BROWN (for himself, Ms. WARREN, and Mr. MARKEY) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 95

Whereas Dr. Paul Farmer, who pioneered novel community-based strategies for the delivery of high-quality health care in impoverished settings, inspired a paradigmatic shift in global health, including inspiring robust United States leadership to address the global HIV/AIDS epidemic in the early 2000s through the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis, and Malaria;

Whereas, in spite of progress made in global health, weak health systems continue to cause millions of people, primarily the global poor, to die tragic and unnecessary deaths, including—

(1) annually, approximately—

(A) 680,000 deaths from HIV/AIDS;

(B) 1,500,000 deaths from tuberculosis;

(C) 627,000 deaths from malaria;

(D) 295,000 deaths of mothers during and following pregnancy and childbirth;

(E) 9,560,000 deaths among children under the age of 15; and

(F) 560,000 deaths of children and young adults, living among the poorest billion people in the world, from non-communicable diseases and injuries; and

(2) a SARS–CoV–2 case-fatality rate of up to 300 percent greater in low-income countries than in high-income countries during the first 2 years of the COVID–19 pandemic;

Whereas progress against unnecessary deaths in impoverished countries is being made, but progress is occurring so slowly that—

(1) based on rates of decline from 2013 to 2022, it will take approximately a century for core mortality statistics in low-income countries to converge with those of high-income countries, including—

(A) 92 years for the tuberculosis death rate;

(B) 109 years for the maternal mortality rate; and

(C) 88 years for the under-15 child mortality rate; and

(2) the death rate in low- and middle-income countries from non-communicable diseases and injuries, which make up 40 to 60 percent of the disease burden of those countries, will never converge with that of high-income countries based on rates of reduction from 2013 to 2022;

Whereas weak health systems that fail to prevent unnecessary deaths also lack the staff, health facility infrastructure, and medical technologies required for effective care delivery and disease containment, placing all countries at increased risk of pandemic disease;

Whereas essential medical technologies, such as diagnostics, treatments, and vaccines for diseases that affect the global poor, are frequently unavailable or inaccessible to health systems in developing countries, because—

(1) investing in research and development of technologies for diseases that disproportionately affect the global poor is often unprofitable for pharmaceutical corporations;

(2) costly intellectual property licensing fees from originator companies to generic manufacturers frequently leave the global poor unable to purchase or access medical technologies; and

(3) originator technology companies often refuse to share or license intellectual property to generic manufacturers, which results in limited supply and high prices, as was the case with the COVID–19 vaccine;

Whereas, according to the Lancet Commission on Investing in Health, preventing most avertable deaths and conferring ''essential universal health coverage'' in low- and lower-middle income countries requires an increase in annual health systems resources in those countries of $75,000,000,000 and $293,000,000,000 (in United States dollars as of 2016), respectively;

Whereas, historically, the United States and other global North-supported global health programs have inadvertently entrenched standards of care in low-income countries that would be unacceptable in rich countries by funding only health services narrowly defined as ''sustainable'', ''cost-effective'', or ''appropriate'' in poor settings;

Whereas the effectiveness and efficiency of current United States overseas development assistance for health is often undermined by—

(1) misalignment with the national health plans of the host country;

(2) bypassing delivery systems with parallel inputs, leading to—

(A) fragmentation of care delivery;

(B) poor donor coordination across partners; and

(C) weak health systems;

(3) favoring technical assistance from consultants from high-income countries, especially the United States, over funding health service delivery in beneficiary countries; and

(4) promoting privatization of health services, which weakens—

(A) the public health system;

(B) health care access;

(C) health equity; and

(D) financial risk protection;

Whereas 98 percent of the annual $1,500,000,000,000 in health spending in aid-eligible low- and middle-income countries is mobilized domestically by the countries themselves, and only 2 percent of this spending comes from overseas development assistance for health;

Whereas many of the poorest developing countries lack the tax capacity to mobilize the necessary resources to close the universal health coverage financing gap, meaning unnecessary deaths will continue in the poorest developing countries for the foreseeable future without external donor financing or dramatic increases in domestic tax capacity;

Whereas the inability of many of the poorest developing countries to fully close the financing gap for universal health coverage and the provision of numerous other public goods and services is in part due to the intimate economic links between those countries and high-income countries, including the United States, which have been marked throughout history by acts of violence and coercion;

Whereas these harms have entrenched a global economic architecture of upward wealth redistribution that has resulted in—

(1) depressed wages of workers and artificially low prices of natural resources in developing countries, amounting to an appropriation of tens of billions of tons of raw materials and hundreds of billions of hours of human labor through unequal exchange;

(2) 3,500,000,000 people living under the poverty line of $5.50 from 1993 to 2023, even as global gross domestic product has more than tripled in size during this time;

(3) more financial resources flowing out of developing countries than into developing countries each year, estimated by Global Financial Integrity to total a net negative of $2,000,000,000,000 annually in 2012;

(4) developing countries bearing nearly all deaths and the vast majority of economic losses attributable to climate change, despite rich countries bearing 92 percent of the responsibility for climate change;

Whereas leadership from the United States to close the financing gaps for essential universal health coverage in low- and lower-middle income countries could precipitate increased global health financing from other donor partners, as evidenced by United States leadership that addressed the HIV/AIDS epidemic in the early 2000s, which spurred a 100 percent increase in global overseas development assistance among all donor partners from 2000 to 2006;

Whereas official United States development assistance to lower-middle income

countries is not a supplement for United States action to stop ongoing structural violence and economic injustices preventing countries from financing and delivering universal health care and other social services for their populations; and

Whereas it is the view of the Senate that creating a decent, humane world without tragic, unnecessary deaths requires both a modest but meaningful increase in global health aid funding and a meaningful effort to stop the economic abuse of low- and middle-income countries: Now, therefore, be it

Resolved, That is it the sense of the Senate that—

(1) the Federal Government should adopt a new, 21st century global health solidarity strategy to end medically unnecessary deaths and respond to the full burden of disease in poor countries by—

(A) supporting developing countries to meet the material needs of their health systems by localizing investments in support of national public-sector and local priorities, referred to as ''accompaniment'' by Dr. Paul Farmer, and delivered through what Dr. Paul Farmer called the ''Five S's'', which refers to—

(i) staff, meaning the human resources necessary for high quality service delivery, including clinical staff, transportation teams, and community health workers, especially by—

(I) supporting long-term training and education systems, including medical schools and teaching hospitals to train the health workforce and improve the quality of care across diseases; and

(II) supporting professionalized community health worker programs whereby community health workers are recruited, adequately compensated, comprehensively trained, supported for long-term retention, positioned as bridges to care, and tasked with undertaking community work with appropriate patient ratios and a manageable scope of work;

(ii) space, meaning the infrastructure needed for service delivery at primary, secondary, and tertiary levels to deliver safe and high-quality care to meet all health care needs;

(iii) stuff, meaning the tools and resources necessary for high-quality care provision, including medical supplies, technologies, and equipment;

(iv) systems, meaning the leadership and governance, health information systems, supply chain systems, logistics, laboratory capacity, and referral pathways required to meet the health needs of the population; and

(v) social support, meaning the resources needed, beyond the direct delivery of health care, to ensure effective care; and

(B) financing the discovery and development of new, urgently needed health technologies, such as diagnostics, treatments, and vaccines, particularly for neglected diseases of poverty, and ensuring their availability as global public goods;

(2) the objectives of adopting a 21st century global health solidarity strategy to end medically unnecessary deaths and responding to the full burden of disease in poor countries will require—

(A) increasing annual global health spending to $125,000,000,000, sufficient—

(i) for the first time, to meet the United Nations development assistance target of spending the equivalent of 0.7 percent gross national income on development assistance, which 6 other countries have previously met; and

(ii) to close over 100 percent of the essential universal health coverage financing gap for low-income countries, and 30 percent of the overall financing gap for low- and lower-middle income countries;

(B) optimizing global health delivery spending by—

(i) introducing a new form of coordinated, multilateral fiscal cooperation for global public investment that—

(I) ensures increased and ongoing global public funding of common goods for health; and

(II) exhibits shared governance with global South governments and meaningful participation of civil society, which is also essential for addressing intersectional crises of social inequalities including the climate crisis; and

(ii) ensuring funding directly supports national health plans, public institutions, local priorities, and donor coordination, practices aligned with what Dr. Paul Farmer called ''accompaniment'';

(C) focusing on health service delivery for vulnerable populations, such as—

(i) people living in poverty;

(ii) women; and

(iii) children; and

(D) optimizing research and development spending for neglected diseases of poverty by ensuring the knowledge and technology produced by these efforts remains accessible to all as global public goods;

(3) the Federal Government should pass and enforce laws and use its diplomatic influence to stop ongoing economic harms to developing countries that deplete impoverished countries of the resources required to provide health and social services for their populations by—

(A) supporting debt cancellation initiatives for low- and middle-income countries, particularly countries in need of debt cancellation, across bilateral, multilateral, and private creditors;

(B) democratizing institutions of global governance, such as the International Monetary Fund, the World Bank, and the World Trade Organization, to ensure fair and equal representation among member countries so that low- and middle-income countries can have greater decisionmaking power in the creation of policies that affect them;

(C) supporting a United Nations Convention on Tax and other measures to dramatically reduce tax avoidance, tax evasion, and other forms of harmful licit and illicit financial flows from developing countries through fundamental reform of international tax cooperation;

(D) supporting global labor rights and living wages, such as a global minimum wage set at local living-income thresholds; and

(E) adopting new indicators of progress that measure social and ecological health and abandon gross domestic product as a measure of progress; and

(4) it is the duty of Federal Government to issue reparations, containing multiple elements, including apology, award, and guarantees of non-repetition of harms, for—

(A) the institution of slavery, the subsequent racial and economic discrimination against African Americans that resulted from the institution of slavery, and the impact of these forces on living African Americans, following the establishment of a commission substantively similar to the commission established under the Commission to Study Reparation Proposals for African Americans Act, H.R. 40, as introduced on January 4, 2021;

(B) the harms of colonialism and subsequent forms of imperialism, which have undermined sovereignty, democracy, self-determination, social and economic rights, and human and ecological well-being in both the colonial and post-colonial eras; and

(C) the disproportionate responsibility of the Federal Government for climate breakdown, the burden of which unjustly and overwhelmingly falls on the global South.

AUTHORITY FOR COMMITTEES TO MEET

Mr. WYDEN. Madam President, I have six requests for committees to meet during today's session of the Senate. They have the approval of the Majority and Minority Leaders.

Pursuant to rule XXVI, paragraph 5(a), of the Standing Rules of the Senate, the following committees are authorized to meet during today's session of the Senate:

COMMITTEE ON ARMED SERVICES

The Committee on Armed Services is authorized to meet in open and closed session during the session of the Senate on Tuesday, March 7, 2023, at 9:30 a.m.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

The Committee on Banking, Housing, and Urban Affairs is authorized to meet during the session of the Senate on Tuesday, March 7, 2023, at 10 a.m., to conduct a hearing.

COMMITTEE ON FINANCE

The Committee on Finance is authorized to meet during the session of the Senate on Tuesday, March 7, 2023, at 10 a.m., to conduct a hearing.

SUBCOMMITTEE ON CLEAN AIR, CLIMATE, AND NUCLEAR SAFETY

The Subcommittee on Clean Air, Climate, and Nuclear Safety of the Committee on Environment and Public Works is authorized to meet during the session of the Senate on Tuesday, March 7, 2023, at 2:30 p.m., to conduct a hearing.

SUBCOMMITTEE ON COMPETITION POLICY, ANTITRUST, AND CONSUMER RIGHTS

The Subcommittee on Competition Policy, Antitrust, and Consumer Rights of the Committee on the Judiciary is authorized to meet during the session of the Senate on Tuesday, March 7, 2023, at 3 p.m., to conduct a hearing.

SUBCOMMITTEE ON ECONOMIC POLICY

The Subcommittee on Economic Policy of the Committee on Banking, Housing, and Urban Affairs is authorized to meet during the session of the Senate on Tuesday, March 7, 2023, at 2:30 p.m., to conduct a hearing.

APPOINTMENT

The ACTING PRESIDENT pro tempore. The Chair, on behalf of the President pro tempore, pursuant to the provisions of Public Law 99–591, as amended by Public Law 102–221, appoints the following member of the United States Senate for appointment as a Senate Trustee to the James Madison Memorial Fellowship Foundation: Honorable ROGER WICKER of Mississippi.

ORDERS FOR WEDNESDAY, MARCH 8, 2023

Mr. SCHUMER. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand adjourned until 10 a.m., Wednesday, March 8; that following the prayer